Drug Diversion Exercise Scenarios

Winter 2016

Scenario #1

1. During an audit of Pyxis CII Safe activity in your pharmacy the Pharmacy Director notices that a staff pharmacist has entered the CII safe numerous times in the past 2 months without documenting a valid reason for accessing the safe. The pharmacist entered *** as the reason. No medications are recorded as removed from the safe at the time of these entries. And upon counting, no medication vials are missing from any of the medication drawers.

2. The Pharmacy Director decides to carefully examine of all the medications in the Pyxis CII Safe. Evidence of drug tampering is identified in certain opioids. He/she notices tiny holes in the center of some of the dust cover caps.

3. The Pharmacy Director schedules a meeting with the staff pharmacist, who admits to tampering with the medication vials for "personal use". The staff pharmacist claims that vials were refilled with sterile saline to replace the medication amounts taken out.

Scenario #2

1. A nurse working in the Post-Anesthesia Care Unit (PACU) expresses concern to her supervisor that the morphine she has been administering for pain does not seem to be as effective as usual.

2. The PACU Nurse Manager notifies the Pharmacy Director regarding the nurse's concern. The Pharmacy Director runs an activity report for the removal of morphine from the PACU drug dispensing device for the past few months. He/she notices that is a particular PACU nurse who often removes larger quantities of morphine for patients, including individuals that she is not assigned to provide care. The Pharmacy Director shares the drug pattern with the Nurse Manager.

3. The nurse manager observes the PACU and notices that the implicated nurse retrieves medication from the drug dispensing device and then leaves the PACU.

4. The nurse who took the medication from the drug dispensing device is intercepted before she can re-enter the PACU and is asked to empty her pockets. She begins to protest but hands over two syringes. Both are filled but one has a broken seal.

5. The nurse is interviewed. She states that she has been helping colleagues get meds when they are busy and this is a big misunderstanding. When asked why she left the PACU during her shift, she stated that she left her personal cell in her locker, was expecting an important call and needed to get it. Upon further questioning and when presented with the tampered syringe, she admits to self-administering morphine from the syringe and replacing it with saline.

6. An investigation of various staff reveals that co-workers have seen the PACU nurse at the facility on her days off and at times when she wasn't scheduled to work and in areas of the facility where she does not normally work.

In addition, the local health department has called the Infection Preventionist (IP) about a cluster of acute hepatitis C virus (HCV) infections in individuals who were patients at the hospital. Two of the patients share a healthcare provider and have no traditional risk factors for HCV. Their healthcare provider ordered testing after they complained of symptoms. Both patients tested positive for HCV. They were both previously in your hospital within three weeks of each other. Both patients were in the PACU.

The nurse admits to self-administering morphine and other controlled drugs throughout the hospital (e.g, replacing the syringes that were intended for patients, replacing them with saline and returning the filled syringes to the PACU). The nurse claimed she started diverting morphine about two months ago.

However, nursing attendance records dating back 12 months indicate that the nurse was working in the PACU on days when each HCV-infected patient received morphine injections. The nurse has documentation of completing the hepatitis B series and has documentation of post-vaccination serology; she does not admit to being positive for HCV or any other bloodborne pathogen. The nurse tests positive for HCV. The hospital informs the local health department to alert them to this new development. The health department tells the hospital that they may need to do a patient notification of all patients who may have received medication that was administered/prepared by this employee.

The nurse has worked at your hospital for 18 months. Since both HCV+ patients were in the PACU six months ago, it is determined that a patient notification to all patients who received care in the PACU when the nurse was working within the last year to get tested for hepatitis C and HIV. Since the nurse was seen in various locations, not just her assigned work area, disease investigators from the local health department are unsure of the extent of patient notification. At this point, the hospital estimates that more than 1200 patients were in the PACU during the last 12 months.

Scenario #3

1. During her rounds, the Infection Preventionist (IP) notices that the anesthesia cart was left unlocked in one of the operating suites. She notices that there is a partially used vial of fentanyl and two syringes on top of the cart, one empty and the other filled. An anesthesiologist arrives a few minutes after the IP sees the cart. He tells the IP that he had to run to the bathroom and the rest of the team left for the day. He returns the cart to the lock-up area and leaves for the day.

2. The following week, an anesthesia tech sees a stocked anesthesia cart prepped for morning surgeries just inside the locked door of an operating suite. On the cart he notices pre-filled syringes for the entire day's surgeries. There is also an empty syringe among the filled syringes. The tech begins to wheel the cart to the locked up area, when one of the anesthesiologists enters the operating suite. The doc explains that he was in the bathroom and that cart should be wheeled over to operating suite #3.

3. While cleaning the room in between cases, the tech notices that the anesthesiologist takes one of the syringes and puts it in his scrubs pocket and walks into the bathroom. The tech waits a while and follows him into the bathroom. As the tech opens the door to the restroom, he sees the anesthesiologist at the sink filling a syringe with tap water.

The anesthesiologist tells him that it is not what it looks like and brushes past the tech to the operating suite. The tech tells a co-worker buddy of his what he saw and asks for advice. The tech is unsure whether to tell his supervisor because he doesn't want to get the doc in trouble.